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# Building the HIV Public Health Service Structure by Quality Improvement

Graham F Watts, Sr., Ph.D., & Lauri Wright, Ph.D., RDN, LD/N

## ABSTRACT

*Quality improvement (QI) is a tool in the public health inventory. It has value in that it provides a modality for accelerating science-based intervention into routine public health practice. In doing so, it holds promise to make transparent how care and service systems demonstrate efficiencies in the structure, operations, and outputs that should translate into improvements in population health outcomes. One HIV health services grant in Northeast Florida touches the lives of over 4,200 persons. How to render services so that it maximally benefits all clients is ongoing work. Service recipients engage nine HIV care funded providers, who differentiate on client census, service mix, staffing, expertise, and resources. Past 12-months QI activities indicated that seven of nine providers had implementation scores in the range of 62.32 to 88.90, (one standard deviation of the geometric mean of 74.51). Submitting implemented improvement activities for external evaluation allows for assessment of implementation fidelity and critique of methodology covering review of documents, including an improvement plan, an annual report, and a normative reference document, (NRD); completion of a scoring rubric, which modeled themes in the NRD, and rendering a qualitative, professional judgment of the extent to which agency annual reports operationalized the NRD underpinnings. Such transparency holds the promise to build public trust by demonstrating accountability to diverse stakeholders. Viewed this way, QI in public health is a necessity, not an option*

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## INTRODUCTION

Public health researchers have been the vanguard of population health improvement. Fielding and Briss (2006)<sup>1</sup> outlined the central tenet of improvements in the public's health this way.

Evidence-based public health [is] the process of integrating science-based interventions with community preferences to improve the health of populations. [The time has come for] accelerating the integration of scientific discoveries into routine public health practice and policy... [because] improvements in the health of populations result from the introduction of evidence-informed policies or programs.... Improved workplace safety [and] childhood vaccination are examples.

In the 21<sup>st</sup> century, HIV remains a pandemic that holds specific sectors of the public hostage. For example, recent work by Gant and colleagues (2014),<sup>2</sup> examining HIV diagnoses in Black men 15 years and older in 17 U.S. areas, points to the interplay of structural factors — poverty, socioeconomic status, and neighborhood distress — on disproportionate rates of HIV infection in this group. Hall et al., 2013 discussed critical findings of HIV public health research for HIV public health improvements.<sup>3</sup>

In high-income countries, ...Australia, the United States, Canada, Spain, and France, about a quarter

to a third of people with HIV [receive a late diagnosis. Subtracting] late presentation [from the universe of all HIV diagnoses, then ⅓ to ¼ of] HIV-infected people... engage in care soon after initial diagnosis. [They] have a lower risk for premature mortality, are more likely to achieve viral suppression and lower viral load burden. ...Early initiation of care is... essential... for... HIV prevention through health care, ...screening, and counseling for risk behaviors.

How does this occur? Quality improvement (QI) is the key that unlocks the door to durable viral suppression, "...defined as all plasma viral load values less than 200 copies/mL over... two-years..."<sup>4</sup> QI creates transparency regarding processes and policies that advance improvements in the health of HIV populations.

Early diagnosis of HIV, entry to care, and viral suppression is not instantaneous. Multiple services and systems interconnect to navigate clients to suppressed viral loads. Therefore, research that adds new knowledge that reduces the information gulf between entry to care and sustained viral suppression is central to accelerating efficiencies in public health practice and improvements in the public's health. Awareness of these goals provided the impetus for *The Accreditation Coalition* to define quality improvement

(QI) in public health. Riley and colleagues (2010), summarized the QI definition this way.<sup>5</sup>

Quality improvement in public health is the use of a... defined improvement process, such as Plan-Do-Check-Act, which... [focuses] on activities that are responsive to community needs and [improves] population health. It refers to... [an] ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes, which achieve equity and improve the health of the community. Defined this way, QI is a distinct management process and set of tools and techniques that [upon coordination] ensure that departments consistently meet their communities' health needs and strive to improve the health status of... populations [served].

But achieving continuous improvement can be elusive. It is easy to articulate but challenging to achieve. This dichotomy exists because QI, at its core, "...incorporates the notion of freeing up resources and redeploying them back into the organization.... [Such realignment challenges people in organizations] to fundamentally change how... [they] think and [examine] what they value.... [This dual emphasis] ...can transform how the entire organization behaves and approaches its work."<sup>6</sup>

The elapse of time has increased the number of QI practitioners. QI has become a buzzword in American health care and health services lexicon. Thanks to the National Academies of Sciences, Engineering, and Medicine report, "Crossing the Quality Chasm: The IOM Health Care Quality Initiative."<sup>7</sup> Knowledgeable professionals speak the improvement language well and are convincing. Despite the improvement, rhetoric, "...Americans die sooner and experience more illness than residents in many other countries. ...Even relatively well-off Americans... experience inferior health in comparison with their counterparts in other wealthy countries. [One explanatory factor is] deficiencies in the health system...."<sup>8</sup> Fifteen-year ago, Shojania and Grimshaw (2005) pointed to pervasive quality problems, unsupported QI activities, and the existence of hindrances that thwart implementation of evidence-based services.<sup>9</sup> The picture painted here is not surprising because years ago, "W. Edward Deming pointed out... that persistent problem in organizations stem... from the system: the structure of the work; systemic practices, policies, and methods; and conventional thinking."<sup>10</sup> More recently, as in five-year ago, Taylor and colleagues (2014) decried the pervasive absence of evaluation on how the plan-do-study-act QI improvement methodology works.<sup>11</sup> In 2016, the Agency for

Healthcare Research and Quality published a Webpage titled, *About EvidenceNOW*: Background and Stories from the Field. One of "the goals of EvidenceNOW... [was] to improve patient care in an environment of discovery and change."<sup>12</sup> The passage of time has neither diminished the need for continuous improvement in health services nor evaluation of how positive change occurs. The current climate of health and social policies make understanding improvements in the public's health an imperative.

Improvement in HIV health services in the Jacksonville Transitional Grant Area (JTGA), is a priority. It is a Health Resources and Services Administration policy directive, which originated from Title XXVI of the Public Health Service (PHS) Act §§ 2604(h)(5), 2618(b)(3)(E), 2664(g)(5), and 2671(f)(2).<sup>13</sup> How does the JTGA think of quality improvement? It is "...a sequence of connected and logically ordered activities..."<sup>14</sup> that "...require the alteration of processes within complex social systems that change over time in predictable and unpredictable ways."<sup>15</sup> Portrayed here is reciprocal determinism arising from the interaction of methods, activities, and environment that yields critical performance metrics. It seems simple enough, but is it? Data and facts are at the core of making improvements, but Arah and colleagues, (2003, p. 377),<sup>16</sup> addressed the complexity this way.

Data and facts are not like pebbles on a beach, waiting... [for someone to] pick up.... They... [are] perceived and measured through an underlying theoretical and conceptual framework, which defines relevant facts, and distinguishes them from background noise.

In the local community of Ryan White Part-A providers, nine recipients supply services to over 4,200 clients. In April 2018, the Administrative Agency gave a local HIV health services policy document to funded service providers. In return, all but one provider had a written QI implementation plan approved for execution during the past 12-months. Of the plans approved by the Administrative Agency for implementation, each proposal had a goal and one aim, (objective), aided by activities, roles, resources, person/s responsibility, outputs, outcomes, and a timeline. The release of the document was favorable to the community because since then 78%, (7 of 9) of service providers have changed quality improvement staff. This level of unprecedented turnover has not occurred in over ten years. If ever there was a time when the need exists for strengthening institutional QI knowledge and recreating a service culture that shows accountability for discovery and change, that time is now. Quarterly QI meetings host a forum for data and information sharing, troubleshooting enigmas,

Questions and Answers, and networking. The community has lost quite a bit of professional experiences, but the new, younger staff who already display a willingness to learn and are open to innovation appear ready to wear the mantle of service improvement leadership.

Leadership for improvement in HIV health services requires evidence-based public health practice (EBPH). Two decades ago, Brownson, Gurney, and Land, (1999, ps. 87 & 94 ),<sup>17</sup> highlighted the seminal role of EBPH in health-related services this way.

...EBPH [is] the development, implementation, and evaluation, [DIE], of effective programs and policies in public health. [This unfolds] through the application of principles of scientific reasoning, ...systematic uses of data and information systems, and [proper use] of program planning models. [Unfortunately, in day-to-day service operations], ...potential barriers that may impede the ability of an organization to implement EBPH... [include] lack of leadership in setting a clear and focused agenda for EBPH and lack of a view of the long-term horizon for program implementation and evaluation.

In other words, at a minimum, an EBPH program requires a goal-objective framework for successful program DIE. "...Goals express ideas about the values... pursued..."<sup>18</sup> and objectives operationalize goals. What roles do objectives have in quality improvement? Again, Arah and colleagues offer insights.

...[Objectives are useful] for monitoring, measuring, and managing the performance of... health systems to ensure effectiveness, equity, efficiency, and quality. You cannot [achieve quality] until you have a way to measure it, and you cannot measure it until you can [check it. Therefore, improvement requires] the use of performance indicators or measures to capture a variety of health and health system-related trends and factors.<sup>19</sup>

The purpose of this study was to evaluate funded services providers Annual Continuous Quality Improvement Reports (hereafter ACQIRs). Evaluation, as used here, refer to the assessment of the extent to which the written report provided demonstrable evidence of targeted implementation of quality improvement activities, supported by results, and impacts on the structure, processes, outputs, and outcomes of HIV health and social services during the previous 12-months. Assessment of the QI implementation picture documented in the ACQIR lies at the core of inferences about whether funded service providers have an articulable and named improvement

target and a clear sense of how to achieve specific aims.

## METHODS

*Community-University Partnership:* Recruitment of an unbiased duo of outside experts was central to building confidence in quality improvement feedback. The City of Jacksonville Ryan White Part-A Administrative Agency, a federal Grantee, partnered with the University of North Florida, College of Health, for external evaluation services. Two public health faculty shared program evaluation expertise as citizens concerned about the quality of local Ryan White care and services. After verbal acceptance of the evaluation project, the Administrative Agency emailed all evaluation materials to the university's team lead, who convened an internal meeting to browse the documents and set up a face-to-face meeting to clarify expectations and a timeline.

The formative phase of the evaluation began with two meetings. One Administrative Agency consultant provided context for the evaluation work. That context described the scope of work and requirements, which included completion dates, the scoring guide, the evaluation rubric, the report structure, a summary report of submitted QI plans approved for implementation, and an explanation of the need for both quantitative and qualitative assessment. The evaluation team lead also asked questions, and the ensuing dialog clarified issues raised. Subsequently, collaborators developed a work plan, in the form of a Gantt Chart, which, upon distribution to all stakeholders, communicated expectations and accountabilities for the proposed, evaluative work.

The summative phase of the evaluation began with the two evaluators working independently to review all nine ACQIRs. Each evaluator read every submitted report at least twice: the first time for familiarity and subsequently for analysis. Following the evaluation rubric, which had a built-in scoring guide, the evaluator assigned a score to multiple line items on the rubric, that summed to a value between zero and 100. See Table one in the Appendix. Because each report had two scores, the average of the two scores provided the best estimate of the past 12-months program description of structure, processes, outputs, and outcomes of service delivery. In addition to the average scores, the evaluators also gave free text feedback about the comprehensiveness of the report. See Table two in the Appendix. The timeline for completion of all nine ACQIR evaluations was five weeks but finished in three weeks.

*Data Analysis Plan:* Analyses implemented multiple tests to triangulate decision-making about the decision-integrity of the external evaluation. Three

procedures from the Excel Analysis Tool Pack are available from the menu bar: Data, Data Analysis: ANOVA, Correlation, and Descriptive. Explanations follow!

*One-Way, Single Factor ANOVA* will assess the equality of means of two continuous distributions of ACQIR scores. “ANOVA can be used to [evaluate] the difference between two means. When this ... [occurs], the resulting probability will be the same as the probability that would have been obtained using a t-test; however, the value of F will not be the same as the value of t” (Pyrzack, 2001, p. 97).<sup>20</sup> The condition for rejection of the null hypothesis, ( $H_0$ ), of no significant difference between the two reviewer’s mean scores at a predetermined alpha level,  $p = 0.05$  or  $p = 0.01$ , is a computed value of F higher than the critical value in an F table<sup>21</sup> or a statistical program p-value less than the alpha level.

*Pearson Product-Moment Correlation*, ( $r$ ), will evaluate the size, (strength), and direction of the distributions of ACQIR scores. As a monotonic measure of association, it will show whether scores moved in either the same, (positive  $r$ ), or the opposite (negative  $r$ ), directions, and to what degree. Published cutoff points indicative of degree include “0.00 to 0.10, (negligible correlation); 0.1[1] to 0.39, (weak correlation), 0.40 to 0.69, (moderate correlation), 0.70 to 0.89, (strong correlation), and 0.90 to 1.00, (very strong correlation). ...[Moving beyond assessment] of the strength of the relationship, [computation of] the square of the correlation coefficient...[called the] Coefficient of Determination... [will assess] the proportion of [shared] variance [between the reviewers].”<sup>22</sup>

*Standardization of the ACQIR scores* will allow for the computation of percentile ranks (PR). The PR of a score is the percentage of scores in a frequency distribution that is equal to or below the comparison score. This process has multiple steps. It requires descriptive statistics (mean and standard deviation), derived by averaging across reviewers. Then, for each agency, compute a z-score that expresses the single agency score in standard deviation units on the standard normal distribution that has a mean of zero and a standard deviation of one ( $X \sim n(\mu, \sigma)$ ). Free online statistical resources make reading standard distribution tables unnecessary by their accessibility and ease of use. <https://homepage.stat.uiowa.edu/~mbognar/applets/normal.html> is home to one standard distribution applet, and <https://www.geogebra.org/m/kbjKw7Cd> is home of another. By typing agency score with the ACQIR distributional mean and standard deviation and choice of the picklist item,  $P(X < x)$ , indicative of percentile rank, gives the proportion of scores that is below a

given raw score. In contrast,  $P(X > x)$  gives the proportion of scores above a given raw score.

The qualitative evaluation will supplement the quantitative component to complete the evaluation story. Hence, reviewers will offer free text feedback to strengthen programmatic quality improvement decision-making. Thus, after multiple readings, each reviewer will reflect on the ACQIR reports to capture the QI implementation picture that unfolded during the previous 12-months. Individually, the reviewers will examine whether each story holistically created a word picture consistent with the planned improvement effort approved for implementation. If such a map exists, it would satisfy the reviewers' questions about what happened, achievements and discoveries noted, conclusions drawn or omitted, limitations acknowledged, and directions for the future articulated. After cognitively considering the QI implementation picture on the previously identified determinants, the reviewers subjectively commented on each report’s strengths and weaknesses.

## RESULTS

Descriptive statistics for the distribution of nine agency’s ACQIR scores follow. The theoretical range of scores for the evaluation was 0 to 100. Observed scores yielded the measures of central tendency alongside other summary indices. Mode 81.0, median 80.5, mean 75.6, standard deviation 13.3, standard error 4.4, kurtosis 0.7, skewness -0.3, range 46.5, minimum 51.0, and the maximum is 97.5. The Pearson Product-Moment Correlation for reviewer one – reviewer two was  $r = 0.95_{(R1-R2)}$ . Squaring the correlation yielded a Coefficient of Determination,  $r^2 = 90.03\%$  shared variance.

Statistics from the computation of One-Way Analysis of Variance (ANOVA) for reviewers’ ratings of ACQIRs follow. The analysis was NOT significant,  $F(1, 16) = 0.00763$ ,  $F\text{-critical} = 4.49$ ,  $p = 0.93$ . Hence, the mean ( $\bar{M} = 75.9$ ), and standard deviation, ( $SD = 14.3$ ), for the ratings of reviewer one, was not significantly different from the ratings of reviewer two mean, ( $\bar{M} = 75.3$ ), and standard deviation, ( $SD = 12.7$ ), under the null hypothesis,  $H_0: \bar{M}_{(R1)} \approx \bar{M}_{(R2)}$ , of no difference in means beyond chance variability.

Table 1 (in the Appendix) presents standardized scores and percentile ranks for each agency score (averaged over two raters). By Figure 1, five of the nine Part-A funded providers had scores within 0.5 standard deviations, (67.87 to 81.15), of the geometric mean of 74.51 compared to seven of nine providers with ratings within one standard deviation, (62.32 to 88.90), of the same. Scores in the interquartile range (between the 25<sup>th</sup>, (65.6), and 75<sup>th</sup>, (83.5), percentiles



included six of nine providers. Scores in the upper  $\frac{1}{3}$  of the ACQIR distribution begin at 80.0, which included five of nine, (55.56%) providers. In each tail of the normal distribution lies one provider at the 4<sup>th</sup> (0.0384) and 96<sup>th</sup> (0.9582), percentiles, respectively. These two providers are in the lower and upper 5% of the distribution of scores.

Table 2, (in the Appendix), presents qualitative evaluation feedback. Two of the nine agencies did an excellent job describing strategies for goal [attainment] and [articulated] lessons learned for goals not met. Additionally, there were reasonable and measurable goals with baselines tied to impact. Another two agencies identified appropriate strategies for reaching set goals and assembled a narrative that did a great job of describing goal attainment. Instead of two agencies, there might have been three if another agency's story was easy to follow. Again, another two agencies had measurable objectives with accompanying activities; however, these entities differed in the following respects. One needed to tailor QI activities to match the program's stated goals and objectives. The other agency could expand on directions for the future, which speak to how next programmatic steps become more robust. The last two ACQIR feedback was markedly different from all others. In one instance, the reviewers acknowledged the excellent job of staff adding graphs for visual evidence and the thorough ideas for next [improvement] steps. However, too many missing sections of the report led to the loss of points. In the other instance, the reviewers lamented the lack of objectives and could not judge achievements.

## DISCUSSION

The purpose of this study was the assessment of QI implementation fidelity and its consequences, as documented in written reports. The working assumption of the evaluation was the description of implementation fidelity occurred. Hence, the evaluators looked for reporting of measurements and how data-informed the improvement decision-making process. The inclusion of these factors in the written report sheds light on how the results impacted the structure, operations, outputs, and outcomes of HIV health and social services. In this regard, quality managers, who prepared and submitted ACQIRs had a responsibility to align the annual report with the local QI improvement policy document, and the QI implementation plans approved by the Administrative Agency. The evaluation feedback identified differences in how each narrative captured improvement over the past 12-months. In two cases, reporting deviated from expectations due to the in-and-out migration of quality managers in Ryan White

service organizations, but undoubtedly not due to differences in the raters as confirmed by the non-significant Omnibus One-Way ANOVA.

Local, Part – A Ryan White services have represented QI using the goals-objectives framework. This framework requires identification of baseline states, taking repeated measures to establish a business memory for answering program and system improvement questions, and for making course correction decisions if indicated. The accountability approach enshrined here aims to assure stakeholders that client satisfaction with services, client access to services, and client health outcomes remain HIV health system priorities among funded sub-recipients. Successful delivery of HIV health services relies on the “reciprocal value proposition. Treating clients relationally<sup>23</sup> as opposed to transactionally is customer sensitive and culturally appropriate. Hence, the day-to-day service delivery operations must focus on goals and clearly defined objectives embedded in the QI effort and built on the Plan, Do, Study, Act, (PDSA) methodology. Together, the goals-objectives framework and PDSA cycles provide a package for identifying programmatic information needs. Through database activities, Ryan White service organizations collect and analyze data on program characteristics to generate information about “...improving organizational performance...”<sup>24</sup> Hence, the JTGA, quality improvement strategy, adopted target, goals, objectives framework because it aligns with longstanding, published research on quality improvement,<sup>25</sup> “...planning frameworks for the accommodation of community empowerment...,”<sup>26</sup> and promotion of “...ongoing improvements in the quality of health and health-related support services.”<sup>27</sup>

This study sets forth essential results concerning the local QI goals-objective framework. The normal distribution of ACQIR evaluation scores shows that 56% of funded HIV service providers are in the upper  $\frac{1}{3}$  of the ACQIR distribution of ratings, which begin at 80.0, five points (rounded up), above the mean of 75.6. In terms of the expected number of scores clustered within one standard deviation of the average, there are seven of nine (78%, rounded up), service providers. If one narrows the clustering about the mean to 0.5 standard deviations, that results in five (56%), service providers. Between  $\frac{1}{2}$  to  $\frac{3}{4}$  of all the Jacksonville Transitional Grant Area (JTGA), funded service providers are engaged in the robust implementation of quality management activities. It appears that the assembly and distribution of a cognitive service improvement road map for conceptualizing QI improvement decision-making helped support the work of Ryan White, Part – A

quality managers. As expected, outliers exist in both tails of the distribution of scores. Whereas the provider in the upper 5% of the standard normal-distribution of scores gains recognition as a model service provider, the provider in the lower tail has more work ahead for moving up the percentile ranks. In all situations, regardless of percentile rank, the feedback from this external evaluation is an opportunity for on-going learning, exchange of improvement ideas, and how to communicate QI implementation fidelity.

This study has limitations that require acknowledgment. Only two rates provided assessments. The absence of diversity among the raters may have skewed the scoring. Assessors were academicians. The specific research lenses through which the public health scholars viewed the report findings may have emphasized reporting consistent with scientific studies. If the assumption of the scientific lens is valid, that may impact the scoring. Finally, providers reporting results often give more attention to client care and documenting service records than organizing their work for external review and critique. The addition of external evaluation as a component of the local Ryan White Part—A program requires an adjustment period so that quality managers overcome the learning curve associated with communicating the impact of their work.

Four strengths are apparent in this study. 1.) The use of external, local, public health evaluators provided a breadth of experience and objectivity of assessment. 2.) By utilization of a goals-objective framework to construct on-going QI, the methodology empowers service providers by the transmission of control to the implementation entity for decision-making, direction setting, priority setting, and course correction. 3.) Freedom to tell the improvement story in a semi-structured way is an opportunity for service providers to frame the narrative from their unique organizational culture perspective. 4.) Feedback from reputable third-party evaluators who are not rooting for a specific agency builds recipients' confidence in evaluation findings.

## **Conclusions**

The overarching story of this study is the robust service improvement culture that exists among most Ryan White Part – A funded providers. But our work of continuous improvement and use of goals-objectives for setting improvement directions and priorities is incomplete. That means agencies should use this first-ever completed, external ACQIR evaluation to engage in critical reflection, the celebration of small wins, (successes), and

identification of next steps for building on existing strengths.

Preservation of a collective QI culture is key to the success of Ryan White's care and services at the systems level. To that end, the trilateral partnership between the City of Jacksonville Ryan White Part-A Quality Administrative Agency, the JTGA HIV Health Services Planning Council, and the University of North Florida College of Health worked seamlessly to provide the impetus for guiding services to desired endpoints using data and processes for decision-making. Evaluation feedback, if credible, and if received with confidence, is essential for the improvement in client care. Hence, the next critical steps involve the communication of evaluation findings to multiple stakeholders. The authors are communicating in this article, pointing out the strengths and the limitations of the effort, fielding local questions and providing honest answers to inquiries, accepting feedback that comes from these public discourses, and integrating feedback into the jurisdiction's quality improvement model. Such inputs have already resulted in updating the jurisdiction's local QI policy document.

Directions for the future are these. Keep an open dialog with funded providers to better understand their unique challenges in making service improvements. Work collaboratively with funded providers to manage growth by development of carefully and surgically crafted annual quality management plans. Encourage systematic documentation of improvement activities and incorporate public sharing of enhancements at the quarterly QI meetings. Increasing the jurisdictional mean QI score and decreasing the standard deviation and standard error scores are long-term goals. The JTGA looks forward to on-going QI learning and growth and hopes for a future with a uniform distribution of QI scores across all funded service providers.

## **Implications for Public Health Practice**

Public health includes a focus on workforce preparedness. One aspect of this preparedness is participation in the improvement of organizational capacities. For both public and private Community-Based Organizations delivering HIV health services, quality improvement implementation, documentation, and reporting can help with the translation of program goals and objectives into client-centered activities that go beyond merely increasing access to services. For the public health infrastructure to do its part in mitigating health disparities, a highly trained and competent workforce must make transparent how systematic improvements in service delivery occur. Both internal and external evaluation has a role in

providing feedback that holds promise to strengthen the science-based of HIV health services delivery.

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## **APPENDIX**

**Table 1: Quantitative Evaluation of Part – A Providers Annual Conformance to Quality Improvement Reports: April 7, 2018 to April 7, 2019**

Agency	Reviewer-1	Reviewer-2	Scores	Scores in Standard Deviation Units	Percentage of Distribution Below Each Score
One	98	97	97.5	1.73	95.82%
Two	86	83	84.5	0.75	77.39%
Three	86	76	81.0	0.49	68.73%
Four	80	82	81.0	0.49	68.73%
Five	79	82	80.5	0.45	64.35%
Six	68	72	70.0	-0.34	36.71%
Seven	71	67	69.0	-0.41	33.92%
Eight	66	66	66.0	-0.64	26.10%
Nine	49	53	51.0	-1.77	3.85%

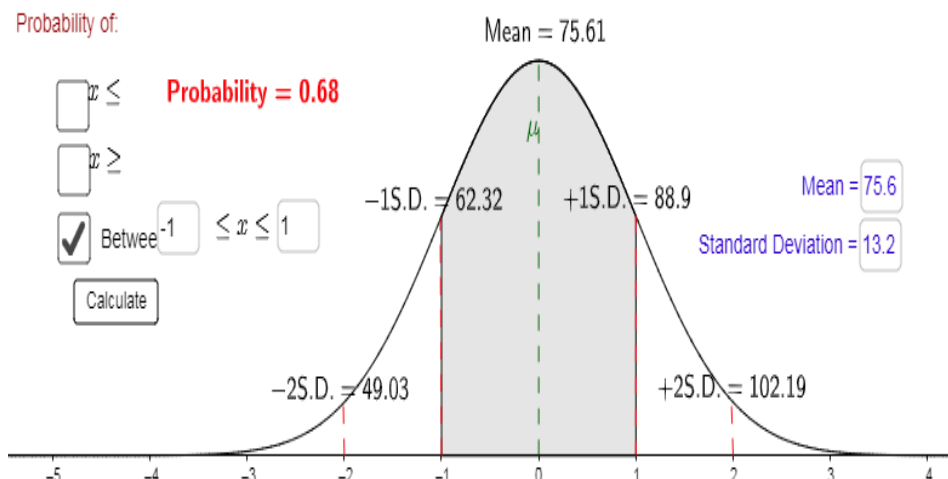
Notes: Scores in standard deviation units are z-scores, and percentage of the distribution below a reference score is the percentile rank



**Table 2: Qualitative Evaluation of Part - A Providers Annual Conformance to Quality Improvement Reports: April 7, 2018 to April 7, 2019**

Agency	Score	Reviewers' Comments
One	97.5	Excellent job describing strategies for goal achievement and lessons learned for a goal not met.
Two	84.5	Reasonable, measurable goals with baselines tied to impact
Three	81.0	Good strategies identified. Goal/objective achievement well described
Four	81.0	An in-depth description of activities and lessons learned; next steps limited to q cards
Five	80.5	Two goals and two objectives. The narrative is a bit difficult to follow Best areas of the report: 1. Nice formatting, [quite] easy to find all the essential parts of the story. 2. Great ideas for improvement activities, very specific.
Six	70.0	Opportunities for improvement: 1. Discussed _____ services several places throughout the report, although this may be a beneficial service that clients receive, it does not directly relate to the program's stated goals and objectives and therefore should be eliminated. Or in the future, add another goal/objective about these services. 2. [It] looks like no baseline... was established due to incomplete data. Expand more on the barriers that impeded the results, what did you learn from this? How could this barrier be avoided in the upcoming years?
Seven	69.0	Measurable objectives provide supporting activities, [but the need exists to strengthen] next steps Best areas of the report: 1. Thorough ideas for the description of the next steps. 2. Excellent job adding graphs for visual evidence.
Eight	66.0	Opportunities for improvement: 1. Many points lost due to missing parts of the report (e.g., cover page, introductory page, CQM table, etc.). The story also lacked organization; it was challenging to find some of the required elements.
Nine	51.0	No objectives provided so cannot judge achievements

**Figure 1: Normal Distribution of Part – A Providers Annual Conformance to Quality Improvement Reports Scores**



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